CHAPTER 6
THE PLANNED SYSTEM OF CARE FOR OLDER ADULTS

WHAT ARE THE VISION, MISSION, AND VALUES FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

The mental health constituency envisions a society in which older adults live in families[1] that support and value their ability to be happy, healthy, and resilient. The public mental health system promotes this vision through participation in a culturally and linguistically competent community-based system of care, which fosters a life-span approach. The purpose of creating a public mental health system that collaborates with the social, health, and long-term care systems of care is to accomplish the following goals for older adults and their families:

- Older adults are healthy
- They are safe
- They live at home
- They engage in meaningful and productive activities
- They have supportive relationships with others
- They have meaningful connections to their communities
- They abide by the law

Counties may be in different stages of implementing an Older Adult System of Care or they may have different needs for mental health components outlined in this chapter. The following values should guide counties when implementing an Older Adult System of Care:

1. **Quality of Life—**The ultimate goal of the older adult system of care is to establish or re-establish quality of life as defined by the older adult in partnership with his or her family and community natural support system. Recovery is supported by timely access to high quality clinical services of demonstrated effectiveness delivered by skilled and motivated clinical personnel who can use culturally based interventions as defined by the clients' culture. Culturally based practices that are identified and selected by the client should be integrated components of quality clinical care.
2. **Client Strengths**—Services should focus on assets and strengths of older adults and on using those strengths to help older adults retain a sense of identity, dignity, and self-esteem.
3. **Empowerment**—Services should be provided in a manner promoting the fullest possible personal control over one's life.
4. **Self-help**—Continued effort should be made to develop service systems, such as peer counseling programs, that focus on self-help and use older persons as mental health service providers.
5. **Cultural and Linguistic Competence**—Services should be provided in a manner respecting a client's culture of origin, particularly for older adults who have strong ties to cultural approaches to mental and physical health care. Staff composition should reflect the ethnicity and language of the client population.
6. **Assessment and Treatment Protocols—**Assessment, treatment protocols, and guidelines should be age-appropriate and gender-appropriate. Services should meet the special needs of older women and reduce the barriers to services they face, including poverty, isolation, failing health, and substance abuse.
7. **Access to Community-based Services—**Access to services must include mobile outreach services because older adults have unique problems that limit their capacity to access services. These problems include lack of mobility, social isolation, sensory losses, and development of age-associated physical problems. Mental health services

[1] The term "family" is used in its broadest sense to include any adult engaged in supporting the older adult in his or her life.

should be provided in the least restrictive, most natural setting possible, including senior centers, housing programs, nutrition sites, nursing facilities, and other residential and community settings.

8. **Preventing Inappropriate Institutionalization**—Systems of care must place a high priority on providing services to older adults with serious mental illnesses at risk of inappropriate institutionalization, especially older women with mental illness who are at greater risk of institutionalization than their male counterparts. When institutionalization cannot be prevented, it should be for the minimum length of stay needed to achieve a therapeutic outcome.
9. **Preventing Suicide**—Services should provide for appropriate screening and assessment for depression and other risk factors, signs, and symptoms associated with suicide among older adults.
10. **Multidisciplinary Service Coordination**—Older persons with multiple problems, such as mental illness, physical disabilities, and substance abuse, may encounter multiple service providers; therefore, mental health planning requires multidisciplinary service coordination. Communities must establish formal linkages among providers of health care, social services, aging services, drug and alcohol programs, developmental disabilities services, and mental health services.
11. **Medical/Psychiatric Interface**—General medical conditions can cause or contribute to mental impairment. The system of care should strive for an integrated, cost-effective diagnostic and treatment interface between the physical health care system and the mental health care system. Difficult medical cases should be handled through appropriate referrals.
12. **Family and Community Involvement**—Involving families in planning, implementing, and evaluating programs for older adults is a crucial element. Services should take place in an environment that includes family, friends, clergy and the spiritual community, and other informal support groups.
13. **Support Services for Caregivers**—Support services should be provided for caregivers of older adults since burn out of caregivers has been identified as the single most important factor contributing to premature institutional care.
14. **Education and Prevention—**Mental health promotion and wellness activities should be available to older adults. Written materials should be understandable, in the person's primary language, and in large print.
15. **Multiple Funding Sources**—Service availability for older adults will require using all funding resources available to meet the mental health needs of older adults, including federal, state, local, and other third-party payers.

WHAT SHOULD THE TARGET POPULATION BE FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

Older adults in need of mental health services have three routes for establishing eligibility to receive publicly funded mental health services: the target population definition for realignment-funded services, the Medi-Cal medical necessity definition, and, if they live in four specific geographic catchment areas for the Older Adults System of Care Demonstration Project, the target population definition for that project.

Target Population Definitions

Target populations for mental health services funded by realignment revenue are contained in the Welfare and Institutions Code (WIC), Section 5600.3. This definition applies to both adults and older adults. To the extent resources are available, an adult or older adult who meets the following target population definition is eligible to receive mental health services from county mental health departments:

- A person who has a serious mental disorder who also meets the following criteria:

  - Diagnosis of a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance abuse or developmental disorder or acquired traumatic brain injury unless that individual also has a serious mental disorder as defined in the statute,
  - As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms, and
  - As a result of a mental functional impairment and circumstances the person is likely to become so disabled as to require public assistance, services, or entitlements.
- A person who requires or is at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence, and
- A person who needs brief treatment as a result of a natural disaster or severe local emergency.

Mental health services are also funded through Medi-Cal. To be eligible for services reimbursed through Medi-Cal, Medi-Cal beneficiaries must meet the medical necessity criteria, which are described in Title 9, Chapter 11, Section 1830.205. The complete medical necessity definition is provided in Appendix I.

To satisfy the medical necessity definition, beneficiaries must meet three criteria: one related to diagnosis, one related to impairment, and one related to intervention criteria. A beneficiary must be diagnosed by the mental health plan with specific diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association (see Appendix I for the complete list of diagnoses).

As a result of the listed mental disorders, a beneficiary must have a significant impairment in an important area of life functioning or probability of significant deterioration in an important area of life functioning.

The final criteria for medical necessity relates to the intervention. Each of the intervention criteria listed below must be met:

(A) The focus of the proposed intervention is to address the identified impairment.

(B) The expectation is that the proposed intervention will:

  1. Significantly diminish the impairment, or
  2. Prevent significant deterioration in an important area of life functioning.

(C) The condition would not be responsive to physical health care based treatment.

When all three of these criteria are met (diagnosis, impairment, and intervention criteria), beneficiaries shall receive specialty mental health services for an included diagnosis even if a diagnosis that is not included is also present. Thus, individuals with dementia could receive mental health services as long as they also have a mental disorder included in Appendix I.

The third target population definition is for the Older Adults System of Care Demonstration Project.[2] It has the following elements:

5689.2. (a) The target population to be served pursuant to this article shall be adults who are 60 years of age or older, diagnosed with a mental disorder, as defined by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, who have a functional impairment, and who meet any of the following criteria:

(1) Are severely and persistently disabled.

(2) Are acutely disabled.

(3) Are impacted by disasters or local emergencies.

(b) For purposes of this article, "functional impairment" means being substantially impaired in major life activities because of a

[2] This project is described more fully later in the chapter in the section entitled, *What State-Level Initiatives Have Been Established For Older Adults?*

mental disorder in at least two of the following areas on a continuing or intermittent basis:

(1) Independent living.

(2) Social and family relationships.

(3) Vocational skills, employment, or leisure activities.

(4) Basic living skills.

(5) Money management.

(6) Self-care capacities.

(7) Physical condition.

Eligibility and Funding Issues

Older adults in need of mental health services fall into three categories: some have only a mental disorder; some have co-occurring mental disorders, such as depression and dementia or depression and substance abuse; and some have dementia with psychological symptoms, such as psychotic symptoms or depressive symptoms, which respond to mental health treatment. Older adults who are severely and persistently disabled by a mental disorder listed in the medical necessity criteria will meet all three target population definitions.

Older adults with dementia face unique challenges accessing publicly funded mental health services, and each target population definition poses different challenges. The Medi-Cal medical necessity definition is the most restrictive. With this definition, an older adult must have co-occurring diagnoses of a mental disorder, such as depression or bipolar disorder, and dementia.

The problem is that for a significant proportion of older adults seeking mental health treatment the only mental disorder with which they can be diagnosed is dementia. As a result, they do not meet the Medi-Cal medical necessity definition. Noncognitive psychiatric disturbances are common in patients with dementia, with at least a third of them exhibiting psychotic and/or depressive symptoms (Dilip, Alexopoulos, & Bartels, 1999). The Stanislaus County Older Adult System of Care Demonstration Project substantiates this estimate. It reports that in its first year 71 (26%) of the 275 older adults who were assessed for need of mental health treatment had a dementia-only diagnosis (Mallock, 2002).

The target population definition for realignment-funded services in WIC Section 5600.3 is more inclusive than the medical necessity definition, but it poses different problems for access to mental health treatment. Older adults with co-occurring diagnoses of dementia and a mental disorder would be eligible for services as would an older adult with only a diagnosis of dementia who was experiencing psychological symptoms, such as depressive or psychotic symptoms. However, in reality realignment funds would rarely be used to treat older adults with dementia because county mental health departments for the most part have to use realignment funding for their required match to the federal Medi-Cal reimbursement they receive. Legally, counties are required to meet the needs of their Medi-Cal beneficiaries.

Moreover, county mental health departments are reluctant to serve clients with dementia because when these clients are admitted to acute psychiatric facilities they frequently remain in these facilities on administrative day status because appropriate residential placements cannot be found for them in the community.

In fiscal year 1999-2000, clients with dementia who were Medi-Cal beneficiaries were on administrative day status an average of 31 days per client before another placement could be found for them. This length of stay is more than double the average length of administrative day stays for most other diagnostic groups. Moreover, the average length of administrative day stays has been increasing for clients with dementia. In fiscal year 1998-99, it was 19.4 days for Medi-Cal beneficiaries with dementia. Clients are placed on administrative day status when they no longer require the acute level of care and are ready to be discharged.

Administrative day status is disadvantageous to the county mental health department because the administrative day reimbursement rate does not cover the cost of care. Combined with the lack of adequate residential placements in the community, the administrative day rate serves as a disincentive to treat clients with dementia needing mental health treatment. In addition, clients with dementia have ever increasing medical needs that the mental health system is not equipped to handle.

The Older Adults System of Care Demonstration Project is the most inclusive service system because of its target population definition and its funding sources. The target population definition does not place any restrictions on the mental disorders in the DSM that qualify a person for mental health services. Thus, an older adult with dementia and psychological symptoms is eligible for services.

The Older Adults System of Care Demonstration Project is funded with $2.015 million from the Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant. The pilot projects are operating in four counties: Humboldt, San Francisco, Stanislaus, and Tuolumne.

Staff from the pilot projects report that they assess all older adults requesting mental health services. Then, the diagnosis determines the treatment plan and funding stream. The pilot projects have three funding streams: the SAMHSA Block Grant, realignment funds, and Medi-Cal. Older adults with co-occurring diagnoses of dementia and a mental disorder meet the Medi-Cal medical necessity definition. Older adults with a diagnosis of dementia and psychological symptoms would be eligible for services funded by realignment or the SAMHSA Block Grant. The SAMHSA Block Grant funds that the pilot projects receive are the most flexible funding source that enables the pilot projects to respond to the needs of these older adults. Some pilot projects take advantage of all three sources of funds; others use only the SAMHSA Block Grant funds.

Recommended Target Population Definition

The target population definition in WIC Section 5689.2 for the Older Adults System of Care Demonstration Project should be the definition used for the Older Adult System of Care when sufficient resources become available. In addition, other populations should also receive publicly funded mental health services, including persons with adjustment or other disorders who do not have acute or high-risk symptoms. These persons would usually benefit from outpatient or peer counseling services. Unless they receive mental health services, they sometimes become members of the target population. Wellness programs reaching older adults who are not currently ill but who might become ill at some point would also be beneficial should additional funds become available. These programs might include educational efforts for older adults on how to deal with bereavement and other issues.

The Older Adult System of Care must have sufficient unrestricted fiscal resources to serve older adults meeting the recommended target population definition who need mental health services. The funding should not be limited to older adults with co-occurring mental disorders as it is for the Medi-Cal necessity definition. The State should design a comprehensive system of care to meet the needs of older adults for health care, mental health care, and residential care in their communities. Because adequate resources would be appropriated to fund this system of care, county mental health programs would not be reluctant to offer their services to clients with dementia because they would know that they would be reimbursed for services that they provide and that the other service components that older adults need would exist.

The target population definition and adequate funding are two of the basic components of a system of care. The remaining sections in this chapter describe the other essential elements for developing a system of care.

WHAT ARE THE MAJOR PROBLEMS AND NEEDS OF OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES?

Older adults are one of the most underserved groups in California's mental health system, yet they are the fastest growing segment of the State's population. The incidence of psychosis among older adults is more than double the rate for individuals 20 to 35 years of age (Cohen, 1980). Fourteen percent of California’s population is 60 years of age and older. By the year 2010, the first influx of baby boomers will constitute 29.2 percent of California’s total population over 60 years of age. By the year 2020, baby boomers will constitute 70.2 percent of California’s total population over 60 years of age. By the year 2020, older adults will represent 21 percent of California’s total population. The National Institute of Mental Health reports that about 15 to 25 percent of persons over age 60 will require some form of mental health services. In addition, the influx of immigrants who are indigent is increasing the utilization of public

mental health services. However, the actual rate at which older adults use mental health services nationally is unknown due to lack of adequate, valid data.

Older adults have special problems that must be considered in developing the types and mix of services to be provided. Among these problems are increasing cultural and linguistic isolation, substance abuse and misuse, sensory loss, homelessness, economic hardship, cognitive impairments, decreasing physical mobility, increasing physical and bio-chemical impairments, poor nutritional status, comorbidity, vulnerability to overmedication, and loss of interpersonal, social, and family support networks that make treatment more complex.

Older adults have a wide range of mental health problems, including depression, which if not properly diagnosed and treated frequently result in high suicide risk and a functional disorder resembling dementia. Indeed, men over the age of 75 have the highest suicide rate in the population. Despite the severity and prevalence of mental disorders among older adults, most of them do not access mental health services. Barriers to mental health care for older adults include:

- The stigma this age group associates with mental illness
- Cultural and linguistic barriers that are encountered by multicultural persons and their families when seeking mental health services
- Isolation of older adults
- Lack of accessibility, availability, and visibility of services
- Lack of transportation
- Lack of staff adequately trained to provide age-appropriate services
- Prevailing myths regarding inability of older adults to benefit from mental health intervention
- Lack of adequate integrated assessment of mental and physical problems that contribute to impaired mental functioning

As the demographics of California changes, the proportion of older adults who are bilingual and monolingual increases. These older adults have special problems as they age. Bilingual older adults, who previously may have been able to function in English, may experience a decrease in their English fluency and may revert to their primary language as a part of the normal aging process. Under stress and mental illness, this process becomes even more pronounced. Attention needs to be paid to this population who previously were able to address their needs in English. Provisions for increased bilingual, culturally competent staff and trained interpreters/cultural brokers needs to be made in the system of care for older adults.

Another problem that older adults with psychiatric disabilities face is that as they age they have an increase in illnesses and injuries, which often result in permanent or temporary physical disabilities. Since this population frequently lives alone or in group housing situations, family support is often unavailable to provide temporary or permanent care to allow them to remain in their own housing. As the amount of publicly funded in-home support services (funded under county social services departments) and home health services (funded by Medi-Cal or Medicare) is severely limited, older adults with psychiatric disabilities who experience illness or injury are frequently forced into residential care, institutions for mental disease, or convalescent hospitals to receive this level of care.

WHAT SERVICES AND PROGRAMS SHOULD BE PROVIDED TO OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES?

In developing a system of care, these minimum service standards are required: early detection and prevention, mobile and clinic-based outreach, assessment, and treatment, medical screening, crisis intervention, medication services, including education about medication management and symptoms, service coordination, day treatment services, 24-hour acute care, community support and rehabilitation, senior peer counseling, and residential services. All services provided should be culturally, racially, and linguistically respectful and competent.

A system of care for older adults must include a comprehensive medical and psychiatric model. For older adults suffering from multiple and severe illnesses, service coordination, including the interface with medical providers, will be

increasingly important. As symptoms increase in severity, older adults experience reduced mobility and have an increased need for mobile services. For older adults, home-based mental health services are most cost-effective compared to the high cost of hospitalization or emergency room visits.

Table 1, which follows, lists all the services that should be in place in each county in order to have a comprehensive system of care for older adults. This table describes the optimal system of care; however, no county has implemented such a full range of services. Service providers should be cognizant of ethnic, cultural, and linguistic issues and should integrate these issues into mental health and other services. The following principles should be considered in developing services for older adults:

- Degenerative brain disorders are a disease process and not a normal process of aging
- A complete psychiatric assessment for older persons must include a physical and psychosocial evaluation
- Older persons can respond to psychotherapy and other forms of counseling and rehabilitation treatment
- A comprehensive array of services will include service coordination and family support, when available, to ensure continuity of care throughout treatment and appropriate coordination with social support services and medical treatment
- A multidisciplinary team approach is essential in diagnosing and delivering mental health services
- Programs for older adults must provide transportation for clients and staff to ensure frail or homebound older adults receive services
- A comprehensive system of care for older adults must be culturally and linguistically competent and should include family members and other support systems, such as traditional and spiritual healers
- All programs should have available staff who are culturally and linguistically competent and specifically trained in caring for older adults
- Older adults need community-based, long-term care services. In-home mental health services should be provided and coordinated with physical health care resources. Adult day health care should be emphasized because it can help older adults remain in the community and also provides respite for family members.
- Counties should develop peer support groups and outpatient treatment programs to prevent older adults from falling through the cracks or becoming more seriously ill. These services should be tailored to consumers in their natural support system.

Table 1

NEEDED COMPONENTS IN THE PROPOSED SYSTEM OF CARE FOR OLDER ADULTS

	County Mental Health	Area Agency on Aging	Local Health Services	County Adult Protective Services	Local Social Services/ Human Services	Local Housing Authority	Local Transportation Agency	Drug & Alcohol Services	Community-based Organizations	Public Guardian/ Conservator	Private Practice Provider	Health Maintenance Organizations	Law Enforcement	Faith-based Organizations	Vocational/ Social Rehabilitation	Higher Education	Caregiver Resource Centers	CA Department of Mental Health	CA Department of Aging	CA Department of Developmental Services
Level I (Prevention)																				
Information & Referral	X	X	X	X	X			X	X	X	X	X		X			X	X	X	X
Outreach/Aging Education	X	X	X		X			X	X		X	X		X			X	X	X	X
Outreach/Pre-Retirement Seminars		X			X				X								X		X	
Transportation		X					X		X	X										
Other Aging Services (e.g., Senior Center, Nutrition)		X							X		X			X					X	X
Friendship Phone Line	X	X						X	X			X		X			X			
Vocational Training/Senior Employment		X							X						X	X			X	

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Socialization		X			X				X			X		X			X			
Health Education		X	X					X	X	X	X	X			X	X	X		X	
Family Support Groups	X	X						X	X			X		X			X		X	
Medical Services for Differential Diagnosis	X		X					X	X		X	X								
Advocacy	X								X	X	X						X			
Money Management				X						X							X			
Assisted Living									X					X						

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Level II (Least Restrictive Intervention)																				
Peer Counseling	X	X	X					X	X					X			X		X	
Outpatient Treatment Services	X		X					X	X		X	X								
Individual & Group Therapy	X							X	X		X	X								
Mobile Crisis	X		X	X				X	X			X								
Walk-in Crisis	X							X	X		X	X								
Mental Health Services Advocacy	X	X						X	X	X							X	X	X	
Day Habilitative Treatment	X	X							X		X	X					X			
Social Day Care		X						X	X								X			

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Support Groups	X	X	X					X	X					X			X			
Respite Services	X	X			X				X		X			X			X			
In-home Supportive Services		X			X				X											X
Mental Health Services at Senior Centers	X	X						X	X								X			
Semi-independent/ Shared Housing	X	X				X	X		X											
Elder Abuse/ Neglect Interagency Team	X	X	X	X	X		X	X	X	X	X									X
Substance Abuse Services (Outpatient & Inpatient)	X		X					X	X		X						X			
Case Management	X	X	X	X	X			X	X	X	X	X		X						X

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Linkages Program		X							X					X					X	
Regional Resource Centers	X								X									X		
Rehabilitation Services										X		X		X	X					
In-Home Health Care									X			X								X
Partial Hospitalization											X	X	X							
Hospice					X							X								
Level III (Moderately Restrictive)																				
Intensive Day Treatment	X								X		X	X					X	X		

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Alzheimer's/ Directed Day Care		X							X		X	X					X		X	
Supervised Group Home	X	X			X			X	X											
Residential Care Facilities for Seniors	X	X			X			X	X											
Therapeutic Foster Care	X	X			X			X	X											
Crisis and Transitional Beds	X			X	X			X	X		X									
Money Management-Representative/ Sub-payee, Power of Attorney	X	X			X				X	X							X			X
Acute Care -- Gero/Medical Psychiatric. (Hospital or Psychiatric Health Facility)	X		X						X		X	X								
Adult Day Health Care		X							X								X	X	X	X

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Multipurpose Senior Services Program/ Ombudsman/ Patients' Rights Advocate	X	X							X								X	X	X	X
LPS/Probate Conservatorships of Person or Estate	X			X	X				X	X										X
Level IV (Most Restrictive)																				
Skilled Nursing Facility	X		X						X		X							X		
Skilled Nursing Facility with Treatment Patch	X		X						X		X							X		
Secure Facility	X		X						X		X							X		
State Hospital	X																	X		

WHAT ARE THE INTERAGENCY PARTNERSHIPS FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

The need for coordination of services with a fixed point of responsibility is paramount. Many services to older adults with mental illness as well as physical health problems are delayed because of the lack of coordination between the mental health system and the medical system. Blended funding is needed to enable mental health providers to offer wraparound services to older adult clients. Concepts need to be changed to modify funding tracks, re-do carve outs with the State, and use blended funding at the local level.

There is broad agreement about the critical need to improve both the range and coordination of services delivered to older persons with mental health needs. Developing a comprehensive, culturally and linguistically competent, coordinated system of care is a major goal. This system of care must include program and service components as well as structures or processes to insure that services are provided in a coordinated, cohesive manner.

A system of care is a comprehensive spectrum of mental health services and other necessary services. These services should be organized into a coordinated network to meet the multiple and changing needs of older persons. The system of care must be more than a network of service components. Rather, it should embody a philosophy about how services should be provided to older persons and their families. The actual components, organization, and configuration of the system of care may differ from community to community. Despite such differences, the values outlined in this chapter should guide the system of care.

Each service dimension in a system of care addresses an area of need for older persons and describes a set of functions that must be performed to provide comprehensive services to meet these needs. Table 1 provides a comprehensive inventory of interagency programs and functions for older adults by level of intervention. This table highlights all the interagency partnerships and agreements that are necessary components in a model system of care to ensure that older adults receive the services they need. Although a county mental health program may not provide all of the services listed, it should work in partnership with the organizations that are listed to ensure that these services are provided in each county. In different communities, different agencies can provide the various types of services. Many of these services can be provided through multi-agency collaborative efforts rather than by a single agency. Such collaborations are important not only in identifying needs and planning services but also in developing, funding, and operating services.

Table 1 identifies the needed components for a proposed system of care for older adults from prevention services to the most restrictive level of services and the agencies that would provide those services. The table begins with Level IV, the most restrictive services. Level IV includes acute and subacute services, which would be provided by agencies, such as the State Department of Mental Health (DMH), private practitioners, county mental health, and community-based organizations. Level III includes moderately restrictive services that are provided by county mental health departments and their contract providers, and other resources at the local level, such as the Area Agencies on Aging (AAA) and caregiver resource centers. For Level II services, all partners previously described are involved in the service delivery at this level, but the system of care expands to include other partners, such as private practitioners, health maintenance organizations (HMOs), cultural and ethnic community support services, and faith organizations. Level I includes prevention services and involves the broadest scope of partners from local agencies to state agencies, such as the State DMH, higher education, and the Department of Aging.

Services to older adults require strong interagency partnerships between primary medical providers and mental health providers. Medication monitoring is an important part of this partnership. Private sector facilities and practitioners can also play a pivotal role in the system of care, providing a wide range of services. Other partnerships include the aging network, social services, adult protective services, the judicial system, and home health agencies. Advocacy is increasingly important in this environment, especially for historically underserved racial, ethnic, and cultural groups. Advocacy plays an active part in collaborative services with organizations that are less

informed on issues of cultural competence to help them become aware of cultural, linguistic, racial, and ethnic differences.

County Structures To Establish Interagency Partnerships

To encourage interagency collaboration with shared responsibility for services, each county needs to have an Interagency Policy and Planning Committee. The local mental health director should be responsible for facilitating the formation of a county interagency policy and planning committee. The members of the committee should consist of the leaders of participating local government agencies, including a member of the board of supervisors, the county counsel, and the directors of public health, social services, mental health, adult protective services, area agencies on aging, and in-home supportive services.

The committee should have the following duties:

(1) Identify those agencies that have a significant joint responsibility for the target population and ensure collaboration on countywide planning and policy

(2) Identify gaps in services to members of the target population, develop policies to ensure service effectiveness and continuity, and set priorities for interagency services

(3) Implement collaborative programs among public agencies and community-based organizations whenever possible to better serve the target population

Counties also need a mechanism for coordinating the care of specific clients. The local mental health director should facilitate the formation of a culturally and linguistically competent multidisciplinary care management team for older adults whose function shall be to coordinate resources to specific older adults who are using the services of more than one agency concurrently. The members of this team should reflect the racial, ethnic, cultural, and linguistic composition of the population to be served and should include representatives from senior social services, alcohol and drug abuse, the conservator's office, mental health services agencies, adult protective services, area agencies on aging, in-home supportive services, and senior centers. These staff must have the necessary authority to commit resources from their agencies to an interagency service plan for older adults. The roles, responsibilities, and operation of these teams should be specified in written interagency agreements or memoranda of understanding.

Formal interagency agreements are necessary to ensure that interagency partnerships operate smoothly. The local mental health director should develop written interagency agreements or memoranda of understanding with the agencies listed below. Written interagency agreements or memoranda should specify services to be provided jointly, staff tasks and responsibilities, facility and supply commitments, budget considerations, and linkage and referral services. The agreements should be reviewed and updated annually.

The interagency agreements may be needed with any of the following county agencies:

(1) Special senior service consortiums, boards, commissions and advisory councils

(2) The court probate and conservator department

(3) The county senior ombudsman office

(4) The county public health department

(5) The county department of drug and alcohol services

(6) Senior legal services

(7) Public transit authority

(8) Other local public, private, or community-based organizations serving older adults

WHAT STATE-LEVEL INITIATIVES HAVE BEEN ESTABLISHED FOR OLDER ADULTS?

The DMH and the California Department of Aging (CDA) are the two state departments with responsibility for initiating programs to serve older adults with mental health needs. This section will describe programs that both departments administer.

Department of Mental Health

The most significant initiative for older adults that the DMH administers is the Older Adults System of Care Demonstration Project. It was established in the Welfare and Institutions

Code (Section 5689 et seq.) in 2000. The DMH funded this project with $2.015 million from the Substance Abuse and Mental Health Services Administration Block Grant. The grants were awarded to pilot projects in four counties: Humboldt, San Francisco, Stanislaus, and Tuolumne. These grants run for three years through fiscal year 2003-04.

Section 5689(a) of the Welfare and Institutions Code requires that "the project be designed to encourage the development and testing of a coordinated, consumer-focused, comprehensive mental health system of care consistent with the recommendations contained in the *California Mental Health Master Plan's* Older Adult Chapter."[3] The legislation also establishes a target population for the pilot projects as well as requirements for evaluation at the state and local levels. In addition, the pilot projects are required to have an advisory structure and to collaborate with other older adult services in the county.

Department of Aging

Under the Older Americans Act, the California Department of Aging (CDA) serves as the State Unit on Aging responsible for the administration of various programs and services designed to meet the needs of adults and seniors through the efforts of 33 Area Agencies on Aging located throughout the State. In addition to serving in a leadership capacity, CDA is an advocate for home and community-based services for California's elderly population. The Area Agencies on Aging fund and monitor the provision of direct services in the areas of information and referral, legal services, nutrition (congregate and home delivered), in-home services, friendly visiting, escort and transportation, service coordination, day care, the nursing home ombudsman program, and respite. The CDA administers the Senior Employment Program, which is available to persons 55 years and over, the Multipurpose Senior Service Program serving persons over 65 who qualify for Medi-Cal, the Linkages program, which assists adults at risk of institutionalization, the Adult Day Health Care Program for persons 18 and over who require rehabilitative services, and the Alzheimer's Day Care Resource Center Program providing dementia-specific services to persons with cognitive impairments and respite for family caregivers. Other programs that could be supportive to persons with psychiatric disabilities include Senior Companions, Foster Grandparents, Brown Bag grocery distribution services, the Health Insurance Advocacy and Planning Program, and the Respite Registry Program. Local mental health departments could establish appropriate ties with these supportive services to assist older adults with psychiatric disabilities to function independently in the community.

Aging with Dignity Initiative

In the Budget Act for fiscal year 2000-01, the Administration committed $271.5 million for the Aging with Dignity Initiative to help elderly people remain at home or with their families rather than in nursing homes. The intent of this initiative is to increase dramatically the availability of innovative community-based alternatives to nursing home care and enhance the quality of care in California's nursing homes.

Caregiver Training Initiative

The Caregiver Training Initiative was established pursuant to Chapter 108, Statutes of 2000 and funded by the Budget Act of 2000-01. The intent of the legislation is to develop and implement proposals to recruit, train, and retain health care providers, such as certified nurse assistants, certified nurses, registered nurses, licensed vocational nurses, and other types of nursing and direct-care staff. The bill also creates an advisory council to develop goals, policies, and a general work plan for the initiative. Membership includes representation from federal, state, and local level government, the health care and home care industries, and organized labor.

Long-Term Care Innovation Grants

The Administration has challenged foundations and private sector communities to partner with the State in an effort to expand innovative

[3] This reference is an earlier draft of the *California Mental Health Master Plan*. Goal 1, to enact legislation to create a pilot project to implement an Older Adult System of Care, from the earlier version of the Older Adult chapter has been moved to Appendix II. This goal has been attained with the enactment of the demonstration project legislation; however, it needs to be retained in the new *Master Plan* because it contains the evaluation requirements for the Older Adults System of Care Demonstration Project.

strategies and alternatives to nursing home placement. The Budget Act of 2000-01 included a $14,250,000 one-time General Fund grant program to implement and expand community-based adult care alternatives to nursing homes. The Administration sought a commitment from private foundations to fund these innovation grants each year for the next ten years.

Long-term Care Council

Chapter 895, Statutes of 1999, established the Long-Term Care Council within the Health and Human Services Agency on June 2000 to coordinate long-term care policy development across multiple departments and programs and to develop a strategic plan for long-term care policy. The Council will also develop strategies to improve quality and accessibility of consumer information on available long-term care programs. It is chaired by the Agency Secretary and includes the Directors of the Departments of Aging, Developmental Services, Health Services, Mental Health, Rehabilitation, Social Services, Veterans Affairs, and the Office of Statewide Health Planning and Development. Since January 2001, the Directors of the Department of Alcohol and Drug Programs, Housing and Community Development, and Transportation have joined the Council.

The mission of the Long-Term Care Council is to provide state-level leadership in developing a coordinated long-term care system that includes a full array of services that promotes personal choice and independence while also assuring fiscal responsibility and equitable access to all long-term care consumers. As one step towards achieving its mission, the Executive Subcommittee of the Long-Term Care Council intends to collaborate with all long-term care stakeholders, including persons with disabilities, their families and representatives, service providers, counties, and public and private entities to expand cost-effective community supports and services to prevent unnecessary institutionalization. In addition, the Long-Term Care Council is organized into other workgroups focusing on specific projects.

SB 639 Task Force

The SB 639 Task Force is one of the projects working under the auspices of the Long-Term Care Council. Chapter 692, Statutes of 2001, (SB 639, Ortiz), required the California Health and Human Services Agency to develop a strategic plan for improving access to mental health services for persons with Alzheimer's Disease or related disorders who also have treatable mental health conditions. The plan will be completed and submitted to the Governor and the Legislature by January 1, 2003.

WHAT ARE THE GOALS AND OBJECTIVES FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

GOAL 1: Ensure that every county mental health department has an Older Adult System of Care.

OBJECTIVE A: The Planning Council shall identify the county mental health departments with an Older Adult System of Care by conducting a survey during fiscal year 2002-03.

OBJECTIVE B: If the Older Adults System of Care Demonstration Project proves to be successful, the State should phase in an Older Adult System of Care for all the counties that do not currently have one. Funds should be appropriated each year and awarded on a competitive basis until all counties in the State have an Older Adult System of Care.

OBJECTIVE C: The Older Adult System of Care development process should include technical assistance and planning grants to those counties that need additional support and assistance in preparing to design and implement an Older Adult System of Care.

GOAL 2: Provide at the state and local levels training and education on the mental health of older adults to reduce stigma and increase public awareness, and improve mental health treatment.

OBJECTIVE A: Local and state mental health and aging programs shall sponsor training for public and private professionals emphasizing physical health, elder abuse prevention, substance abuse treatment, pharmacological issues, differential diagnosis, suicide prevention and ethnically, culturally, and linguistically relevant issues, among older adults.

OBJECTIVE B: Licensing boards for health care professionals who work with older adults shall establish continuing education requirements for geropsychiatric training, including cultural and linguistic competency issues.

OBJECTIVE C: Local and state mental health and aging programs shall sponsor training programs in nursing and residential care facilities on the mental health needs of their clients.

OBJECTIVE D: Local and state mental health and aging programs shall sponsor an annual training conference on issues related to providing culturally and linguistically relevant services to older adults who are members of ethnically diverse groups.

OBJECTIVE E: State and local mental health and aging programs shall develop annual educational programs for older adults that help them increase their understanding and awareness of mental health and aging issues.

OBJECTIVE F: Local and state mental health and aging programs shall sponsor annual training for senior peer counselors and trainers in every county.

GOAL 3: The DMH must work closely with the Department of Health Services to develop a coordinated response to the health needs of older adults.

GOAL 4: The State should develop an appropriate residential continuum for older adults with psychiatric disabilities to enable them to live in the least restrictive, most appropriate setting that meets their needs.

OBJECTIVE A: Housing should be developed which allows individuals to have a live-in caregiver.

OBJECTIVE B: The State should explore expansion of in-home support services, and home health benefits should be expanded to allow individuals to maintain their own housing when, due to illness or physical disability, the individual requires more assistance.

APPENDIX I

Medical Necessity Criteria are described in Title 9, Chapter 11, Section 1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders

(G) Mood Disorders

(H) Anxiety Disorders

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A significant impairment in an important area of life functioning.

(B) A probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life functioning, or

3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

APPENDIX II

GOAL 1: To enact legislation creating a pilot program to implement an Older Adult System of Care.

OBJECTIVE A: Sections in this chapter on target population definition, range of mental health services, and interagency collaboration can be used as components for the Older Adult System of Care legislation.

OBJECTIVE B: For each county awarded a system of care grant, the Department of Mental Health (DMH) shall establish system performance goals and negotiate the expected levels of attainment for each year of participation. A county shall include expected levels of attainment in its proposal. These goals shall include the following:

1) Establish a baseline for the following performance indicators for clients:
   a) The extent to which the target population is served in proportion to their representation in the general population.
   b) The rate at which homeless persons accept services.
   c) The rate at which clients are actively engaged in some community support network as measured by participation in peer support or self-help groups, socialization center programs, or other activities.
   d) The rate at which clients are participating in a rehabilitation program as measured by membership in a psychiatric rehabilitation program, a supported employment program, volunteer programs, or adult day and adult day health care programs for at least one year.
   e) The rate at which multi-problem clients, including those with a secondary diagnosis of substance abuse and seniors with special needs, are receiving a comprehensive program of treatment that addresses their multi-diagnostic needs.
   f) Psychological impairment and functioning for clients in the target population.
   g) The rate at which clients receive income support entitlements.
   h) The rate at which clients remain in the least restrictive, most appropriate housing consistent with their capabilities for at least one year.
   i) The rate at which clients spend time in the local jails.
   j) The rate at which clients with a secondary diagnosis of substance abuse are abusing dangerous drugs, prescription drugs, and over-the-counter medications.
2) Cost effectiveness indicators:
   a) All major public costs for clients, including mental health, housing, social services, vocational and physical rehabilitation, health services (including Medi-Cal and Medicare), adult protective services, and public guardianship.
   b) Costs for state hospitals, local acute inpatient facilities, skilled nursing facilities, institutions for mental disease, crisis residential, and medical facilities.
   c) Costs for criminal recidivism.
   d) Other short-term and long-term costs related to attaining client outcome goals.
3) Measure the extent to which the following system-level goals are attained:
   a) The percentage of clients who meet the target population definition.
   b) The extent to which the joint responsibilities specified in the interagency agreements has been fulfilled.
   c) The percentage of clients with individualized service plans that will facilitate interagency service delivery in the least restrictive environment.

d) To ensure access by older adults to state hospitals, local acute inpatient facilities, skilled nursing facilities, institutions for mental disease, and medical facilities.

e) To develop or provide access to a range of intensive services that will meet individualized service plan needs. These services shall include, but not be limited to, the list of services in Table 1.

f) To ensure the development and operation of the interagency policy and planning committee and the multidisciplinary care management team.

g) To develop caregiver education and support groups and linkages to ensure their involvement in the planning process and the delivery of services.

h) To gather, manage, and report data in accordance with state requirements.

i) To ensure the development of assessment protocols for concomitant physical problems either causing or contributing to mental health impairments.

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